

14. Counter-Transference

D. W. Winnicott

What I want to say can be briefly stated.

I think that the use of this word *counter-transference* should now be brought back to its original use. We can use words as we like, especially artificial words like *counter-transference*. A word like *self* naturally knows more than we do; it uses us, and can command us. But *counter-transference* is a term that we can enslave, and a perusal of the literature makes me think that it is in danger of losing its identity.

There is now quite a literature around the term, and I have tried to study it. In my paper 'Hate in the Counter-transference' (which is chiefly about hate), I said that one use of the word *counter-transference* would be to describe 'abnormality in counter-transference feelings, and set relationships and identifications that are under repression in the analyst. The comment on this is that the analyst needs more analysis. . . .'

For the purposes of that paper I then gave two other possible meanings.

A discussion based on the failures of the analysts' own analyses must be futile. In a sense, this ends the debate.

The meaning of the word *counter-transference* can be extended, however, and I think we have all agreed to extend it a little so that we may take this opportunity to look at our work afresh. I shall return, however, to this idea that I have already expressed. Before I proceed I must go back to a remark made by Michael Fordham at the beginning of his paper, in which he quoted Jung as protesting against the idea that transference was the product of psycho-analytic technique, emphasizing that it was a general transpersonal or social phenomenon. Apart from the fact that I do not know what *transpersonal* means, I think that confusion could arise here by a distortion of the use of the term *transference* as I think Freud introduced it. The characteristic of psycho-analytic technique is this use of transference and of the *transference neurosis*. Transference is not just a matter of rapport, or of relationships. It concerns the way in which a highly subjective phenomenon repeatedly turns

up in an analysis. Psycho-analysis very much consists in the arranging of conditions for the development of these phenomena, and in the interpretation of these phenomena at the right moment. The interpretation relates the specific transference phenomenon to a bit of the patient's psychic reality, and this in some cases means at the same time relating it to a bit of the patient's past living.

In a typical example, a patient is gradually working round to suspicion and hate in the relation to the analyst, which can be seen to have a correlation with the danger of meeting another patient, or with the breaks due to weekends and holidays. In the course of time an interpretation makes sense of all this in terms not of the present but of the dynamic structure of the patient's personality. Following this work the patient loses the specific transference neurosis and begins to boil up for another. (Often the work is not done in such a clear way, but for teaching purposes this might be a fair description of a basic principle.)

Michael Fordham (1960) gave a good example of this in the patient who asked questions. Eventually she said: 'You are like my father, you never answer questions.' Often a patient will have given clues so that the analyst may interpret fruitfully, but here a little bit (but an important bit) of the interpretation was arrived at by the patient, and no doubt the analyst was then able to weigh in with a more complete interpretation.

It is necessary for me to take up time in this way because if we do not agree about the term *transference* we must not start discussing *counter-transference*.

Incidentally, may I remind Dr Fordham that some of the terms he uses are not of any value to me because they belong to the jargon of Jungian conversation. He in turn can tell me which of my words are useless to him. I refer to: *transpersonal*, *transpersonal unconscious*, *transpersonal analytic ideal*, *archetypal*, *the contra-sexual components of the psyche*, *the animus and anima*, *animus-anima conjunction*.

I cannot be communicated with in this language. For some in this hall these are household words, and for the rest they have no precise meaning.

We must also be careful over the use of words that are used in different ways by various groups of workers: *ego*, *unconscious*, *illusory*, *syntonic* (*react syntonically*), *analysis*, etc.

I can now return to the subject of transference-counter-transference phenomena and examine what happens in professional work generally. Professional work is quite different from ordinary life, is it not?

All this started up with Hippocrates. He perhaps founded the professional attitude. The medical oath gives a picture of a man or woman who is an idealized version of the ordinary man or woman in the street. Yet *that is how we are* when professionally engaged. Included in the oath is the promise that we do not commit adultery with a patient. Here is a full recognition of one aspect of the transference, the patient's need to idealize the doctor, and to fall in love with him, to dream.

Freud allowed for the development of a full range of subjective phenomena in the professional relationship; the analyst's own analysis was in effect a recognition that the analyst is *under strain in maintaining a professional attitude*. It is on purpose that I use this wording. I am not saying that the analyst's analysis is to free him from neurosis; it is to increase the stability of character and the maturity of the personality of the worker, this being the basis of his or her professional work and of our ability to maintain a professional relationship.

A professional attitude may, of course, be built up on a basis of defences and inhibitions and obsessional orderliness, and I suggest that it is here that the psychotherapist is particularly under strain, because *any structuring of his ego-defences lessens his ability to meet the new situation*. The psychotherapist (analyst, or analytical psychologist) must remain vulnerable, and yet retain his professional role in his actual working hours. I guess that the well-behaving professional analyst is easier to come by than the analyst who (while behaving well) retains the vulnerability that belongs to a flexible defence organization. (Fordham refers to this same idea in his own language.)

There is a much fuller use of transference phenomena in psychoanalysis than in social work, for instance. This gives a therapeutic advantage to the analyst over the social worker, but it is necessary to remember the advantages that remain with the more general caseworker who, working in with the patient's ego functions, is in a better position to relate the individual's ego needs to social provision. As analysts we are often hampered in this which is not our function.

In analysis the transference neurosis is characteristically id-derived. In social work a man may say to the worker, 'You remind me of my mother.' Nothing need be done about this, except for the worker to believe in it. In analysis the analyst will be given the clues so that he can interpret not only the transference of feelings from mother to analyst, but also the unconscious instinctual elements that underlie this, and the conflicts that are aroused, and

the defences that organize. In this way the unconscious begins to have a conscious equivalent and to become a living process involving people, and to be a phenomenon that is acceptable to the patient.

What the patient meets is surely the professional attitude of the analyst, not the unreliable men and women we happen to be in private life.

I want to make this clear observation first, although later I shall modify what I am now saying.

I want to state that the working analyst is in a special state, that is, *his attitude is professional*. The work is done in a professional setting. In this setting we assume a freedom of the analyst from personality and character disorder of such a kind or degree that the professional relationship cannot be maintained, or can only be maintained at great cost involving excessive defences.

The professional attitude is rather like symbolism, in that it assumes a *distance between analyst and patient*. The symbol is in a gap between the subjective object and the object that is perceived objectively.

It will be seen that here I am disagreeing with a statement of Fordham's although a little later I shall agree with him. The statement I am disagreeing with is the following: 'He [Jung] compares the analytic relation to a chemical interaction, and continues that treatment can "by no device . . . be anything but the product of mutual influence, in which the whole being of the doctor as well as the patient plays a part".' Later he is very emphatic that it is futile for the analyst to erect defences of a professional kind against the influence of the patient, and continues: 'By doing so he only denies himself the use of a highly important organ of information.'

I would rather be remembered as maintaining that in between the patient and the analyst is the analyst's professional attitude, his technique, *the work he does with his mind*.

Now I say this without fear because I am not an intellectual and in fact I personally do my work very much from the body ego, so to speak. But I think of myself in my analytic work working with easy but conscious mental effort. Ideas and feelings come to mind, but these are well examined and sifted before an interpretation is made. This is not to say that feelings are not involved. On the one hand I may have stomach ache but this does not usually affect my interpretations; and on the other hand I may have been somewhat stimulated erotically or aggressively by an idea given by the patient, but again this fact does not usually affect my interpretative work, what I say, how I say it, or when I say it.

The analyst is objective and consistent, for the hour, and he is not a rescuer, a teacher, an ally, or a moralist. The important effect of the analyst's own analysis in this connexion is that it has strengthened his own ego so that he can remain *professionally* involved, and this without too much strain.

In so far as all this is true the meaning of the word *counter-transference* can only be the neurotic features *that spoil the professional attitude* and disturb the course of the analytic process as determined by the patient.

In my opinion this holds except insofar as the diagnosis of the patient is of a certain kind, and I now want to describe the kinds of diagnosis that to my mind alter the whole problem and make me wish to agree with the statement that I have just disagreed with. The subject under discussion is now: *the role of the analyst*; and this role must vary according to the diagnosis of the patient. Neither speaker had time to refer more than briefly to the matter of diagnosis (although Fordham quoted Jung: 'It is clear, however, that he is sure the patient can have very drastic effects on the analyst and that this can induce pathological manifestations in him. He states that this is particularly the case when cases of borderline schizophrenia are being treated' and developed the theme in an interesting way.)

I am now, therefore, speaking from a different position, and the change comes from the fact that I now refer to the management and treatment of borderline cases for which the word *psychotic* is more appropriate than the word *neurotic*. But the vast majority of people who may come to us for psychoanalysis are not psychotic and students must be taught first the analysis of non-psychotic cases.

You might expect me to use words like *psychoneurosis*, *psychosis*, or *hysteria*, *affective disorder*, and *schizophrenia*, but I shall not do so in classifying cases for our purposes here.

Two types of case seem to me to alter the therapist's professional attitude completely. One is the patient who has *an antisocial tendency*, and the other is the patient *who needs a regression*. The first, the patient with more or less antisocial tendency, is permanently reacting to a deprivation. The therapist is compelled by the patient's illness, or by the hopeful half of the patient's illness, to correct and to go on correcting the failure of ego support that altered the course of the patient's life. The only thing the therapist can do, apart from getting caught up, is to use what happens in an attempt to get down to a precise statement of the original deprivation or deprivations, as perceived and felt by the patient as a child. This may or may not involve work with the patient's unconscious. A therapist wholly engaged in work

with patients who display an antisocial tendency would not be in a good position to understand the psychoanalytic technique or the operation of the transference, or the interpretation of the transference neurosis. We try to avoid giving our psychoanalytic students antisocial cases, precisely because we cannot teach psychoanalysis on these cases. They are better dealt with in other ways, though psychoanalysis can sometimes be usefully added. I shall leave aside further consideration of the antisocial tendency.

In the other type of patient to which I refer a regression will be needed. If a significant change is to be brought about the patient will need to pass through a phase of infantile dependence. Here again psychoanalysis cannot be taught, though it can be practised in modified form. The difficulty here is in diagnosis, in spotting of the falseness of the false personality that hides the immature true self. If the hidden true self is to come into its own in such a case the patient will break down as part of the treatment, and the analyst will need to be able to play the part of mother to the patient's infant. This means giving ego support in a big way. The analyst will need to remain orientated to external reality while in fact being identified with the patient, even merged in with the patient. The patient must become highly dependent, even absolutely dependent, and these words are true even when there is a healthy part of the personality that acts all along as an ally of the analyst and in fact tells the analyst how to behave.

You will note that I am now using phrases that are in line with phrases used by Fordham.

Now here again it can be said that analysts who work chiefly with patients who become very fully dependent in this way can fail to understand and learn the psychoanalytic technique that is based on work with the vast majority of patients, those whose own infantile dependence was successfully managed by their own mothers and fathers. (I cannot too strongly emphasize the fact that most people, if analysed, do need the classical psychoanalytic technique, with the analyst's professional attitude in between the patient and the analyst.)

Per contra, the classical analyst, the one who has learned his job and who is confident in his ability to deal with the transference neurosis as it develops and repeatedly redevelops, has a great deal to learn from those who care for and who attempt to do psychotherapy of the patients who need to go through the stages of emotional development that properly belong to infancy.

From this changed position, therefore, with the patient diagnosed as psychotic or schizophrenic, and the transference dominated by the patient's need

to regress to infantile dependence, I find I am able to join up with a whole lot of Dr Fordham's observations, which, however, I think he did not properly link with the classification of the patients because he had not time.

The borderline psychotic gradually breaks through the barriers that I have called the analyst's technique and professional attitude, and forces a direct relationship of a primitive kind, even to the extent of merging. This is done in a gradual and orderly manner, and recovery is correspondingly orderly, except where it is part of the illness that chaos must reign supreme both without and within.

In the training of psychoanalysts and the like we must not place the students in the position of being related to the primitive needs of psychotic patients, because few will be able to stand it, and few will be able to learn anything from the experience. On the other hand, in a properly organized psychoanalytic practice there is room for some patients who force their way across the professional borderline, and who make these special tests and demands that we seem to be including under the term *counter-transference* in this discussion. I could take up the subject of the analyst's responses. In fact I find it difficult to miss this opportunity for discussing all kinds of things that I have experienced and that link up with ideas put forward by Dr Fordham. For instance, I got hit yesterday. What I said is not for publication. It was not an interpretation but a reaction to an event. The patient came across the professional white line and got a little bit of the real me, and I think it felt real to her. But a reaction is not counter-transference.

Would it not be better at this point to *let the term counter-transference revert to its meaning* of that which we hope to eliminate by selection and analysis and the training of analysts? This would leave us free to discuss the many interesting things that analysts can do with psychotic patients who are temporarily regressed and dependent for which we could use Margaret Little's term: *the analyst's total response to the patient's needs*. Under this or a similar title there is much to be said about the use that the analyst can make of his or her own conscious and unconscious reactions to the impact of the psychotic patient or the psychotic part of the patient on his or her self, and the effect of this on the analyst's professional attitude. I am one of those who have already written a little and said much on this subject that interests Jungians and Freudians alike. This could form and must indeed form a basis for future discussions, but I think that only muddle can come from stretching to cover all this the word that is in the title of this symposium: *counter-transference*.

REFERENCES

- Fordham, Michael. (1960). Counter-transference. *British Journal of Medical Psychology* 33 (1): 1-8.
- Winnicott, D. W. (1949). Hate in the counter-transference. In *Collected Papers*. London: Tavistock. 1958.